FOR OFFICE USE ONLY

REG NUMBER: _____

DATE: _____

KANSAS STATE BOARD OF PHARMACY
800 SW JACKSON, ROOM 1414
TOPEKA, KS 66612
(785) 296-4056
FAX (785) 296-8420

FEE: NONE

APPLICATION FOR HEALTH DEPARTMENT OR PRIVATE NOT-FOR-PROFIT FAMILY PLANNING CLINIC OR INDIGENT CARE CLINIC REGISTRATION

This application is being made for the following reason: (check all that apply):

_____New _____Change of Address _____Change of Ownership _____Change of PIC
Previous Kansas License Number (if applicable)_____

_____
Name of Department/Clinic

_____
Address

_____
City State Zip County Phone No.

_____
E-Mail Address

_____
Mailing Address for Renewal Information, **IF DIFFERENT** than the physical location.

_____
City State Zip

(Check appropriate facility)
___Health Department ___Private Nor-For-Profit Family Planning Clinic ___Indigent Care Clinic

_____
Pharmacist-In-Charge Lic. No.

Attach a list of other pharmacists who work at the facility as well as their license number.

Total hours per week pharmacist on duty in facility: _____ (total hours)

I, _____, do solemnly (swear or affirm) that I am the pharmacist-in-charge acting on behalf of the above facility; and that such Health Department, Private Not-For-Profit Family Planning Clinic, or Indigent Care Clinic will be conducted and operated in full compliance with the Pharmacy Law and professional ethics and all other laws of Kansas so long as continued under such registration. I understand that the registration, if issued, will expire annually on the 30th day of June and such registration will be cancelled if not renewed **annually** by the 31st day of July.

Subscribed in my presence and sworn to before me this _____ day of _____ , 20 ____
(Seal)

_____Signature of Pharmacist in Charge

_____Signature of Notary Republic

My commission expires: _____